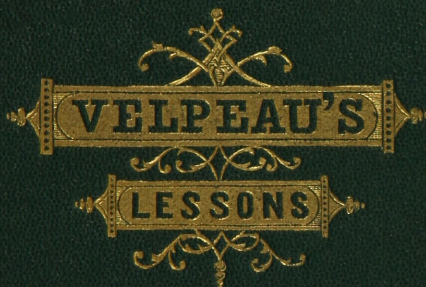


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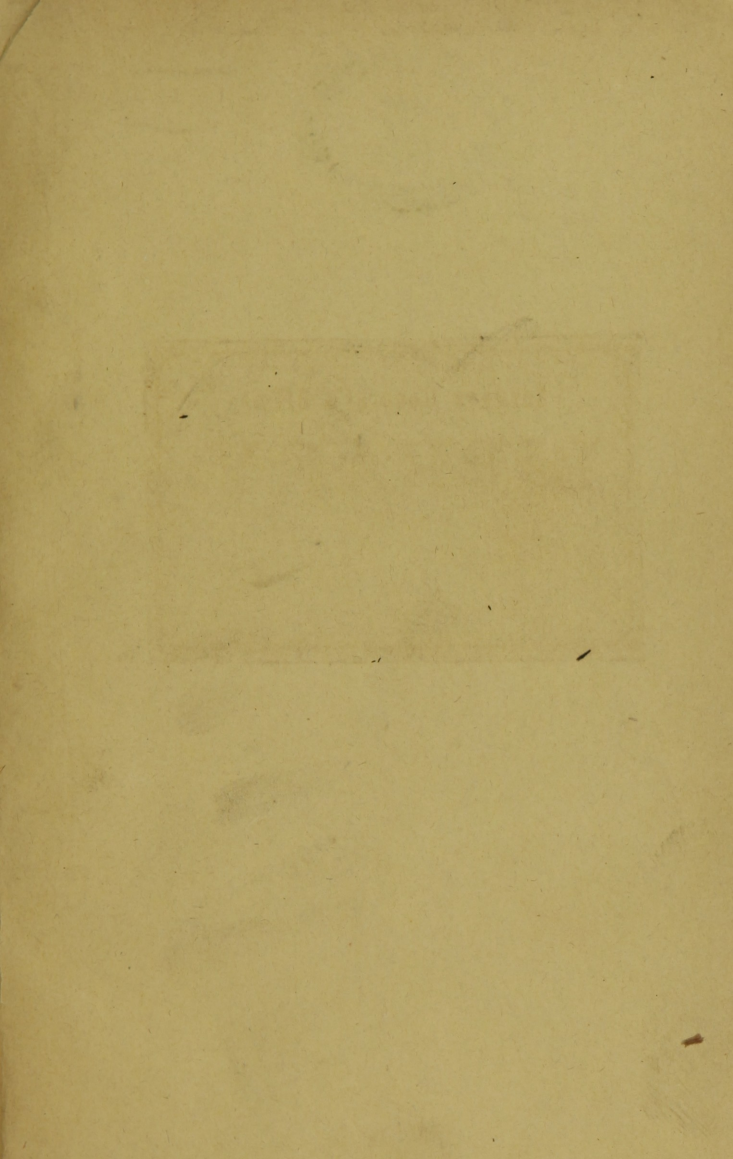


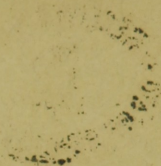
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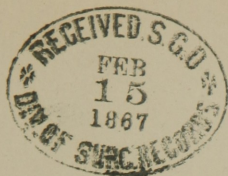
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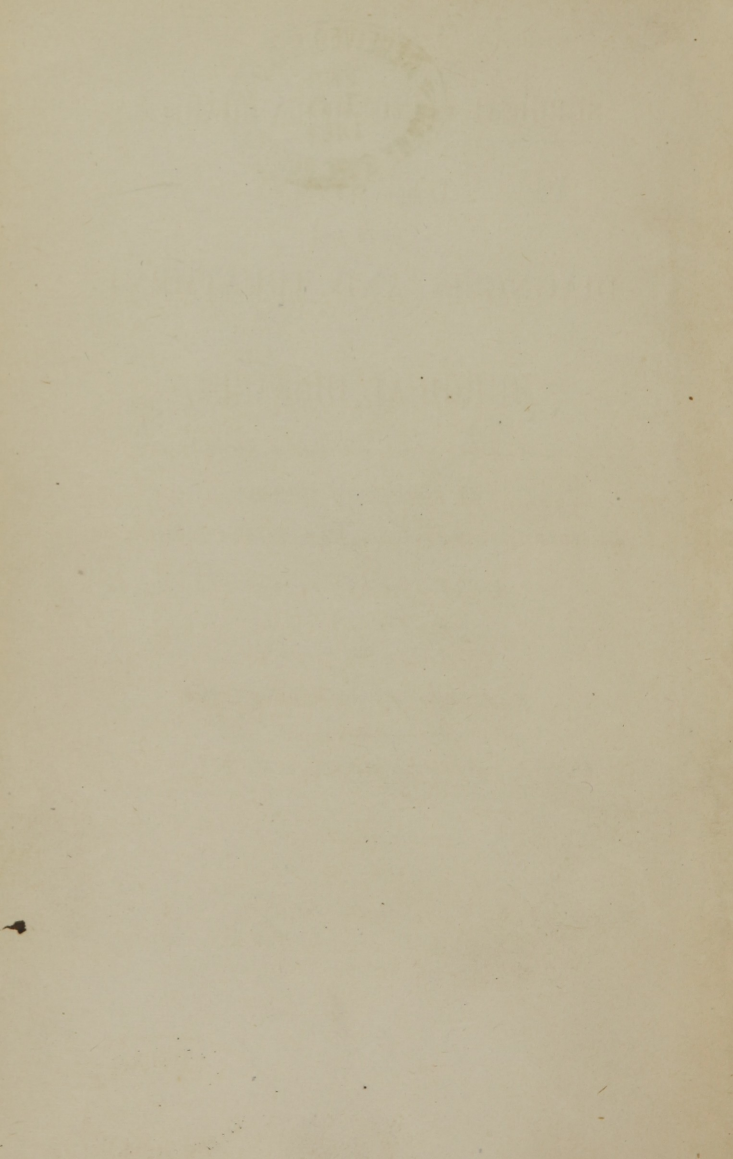












SURGICAL CLINIC OF LA CHARITÉ.

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LESSONS  
UPON THE  
DIAGNOSIS AND TREATMENT  
OF  
SURGICAL DISEASES,

DELIVERED IN THE MONTH OF AUGUST, 1865,

BY PROFESSOR VELPEAU,

MEMBRE DE L'INSTITUTE ET DE L'ACADÉMIE IMPÉRIALE DE MÉDECINE.

COLLECTED AND EDITED BY

A. REGNARD,

INTERNE DES HÔPITAUX.

*REVIEWED BY THE PROFESSOR.*

TRANSLATED BY

W. C. B. FIFIELD, M. D.

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## TRANSLATOR'S PREFACE.

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IN presenting this little work to the American medical public, the Translator has two objects in view: one, to give to the toilers in a most arduous profession, scattered over a vast country, the latest utterances of the King of Surgeons; the other, to establish more firmly, by means of another language, a monumental stone erected by Velpeau in the province of Surgery, marking the commencement of a highway towards Truth. Years have rolled by, since in the province of Medicine, a similar stone was set up by one still among the number of living men, Jacob Bigelow.

Along this highway the profession toils. Of late, a "bold picket" has gone before the host with such rapid footsteps, that we look after him with straining eyes and fear to follow.

Velpeau advances with the heavy tread of a mighty battalion, tears off the cerements that so long enwrapped the fair form of Surgery, and if she stands stripped of the bandages and appliances that have so long arrayed her, she is all the more graceful and lovely.

These pages, although few in number, are yet full of compressed truths; the essence of the long life and vast experience of Velpeau — perhaps the last words he may speak to us. The book also contains matter for the medical jurist; and the practitioner, haunted by the fear of prosecution for malpraxis, may find in the dogmas of Velpeau, firm support in time of trouble.

To the student just embarking in his profession, this little monitor will tell what is done for Surgery by the mighty force called Nature, and how she is best aided by Art. How to estimate the value of remedies, and so to distinguish the natural termination of disease from that produced by medicinal agents, that the course of science may be accelerated by his future observations, not retarded and clouded by false deductions as to the comparative merits of Nature and Art.

W. C. B. FIFIELD.

DORCHESTER, *Sept.* 20, 1866.

## CONTENTS.

	Page
INTRODUCTION . . . . .	7
I. GENERALITIES . . . . .	9
II. FRACTURES . . . . .	13
III. AFFECTIONS OF THE JOINTS . . . . .	29
IV. INFLAMMATIONS AND ABSCESSSES . . . . .	39
V. AFFECTIONS OF THE LYMPHATIC SYSTEM . . . . .	50
VI. BURNS AND CONTUSIONS . . . . .	61
VII. AFFECTIONS OF THE GENITO-URINARY ORGANS . . . . .	68
VIII. AFFECTIONS OF THE ANAL REGION . . . . .	88
IX. AFFECTIONS OF THE EYES . . . . .	92
X. STATISTICS OF OPERATIONS . . . . .	97





## INTRODUCTION.

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LESSONS analogous to those which follow are delivered every year and published in the medical journals, but abridged, particularly in regard to statistics.

Now, if the observations accumulated for nearly thirty years by M. Velpeau have, in this last respect, a considerable importance, the collection of facts gathered during a single year can offer only a secondary interest. Of greater importance, on the contrary, are the remarks which the Professor delivers upon the occasion of these statistics, remarks which are an epitome of his practice.

In view of this, we are certain that these lessons, gathered together in detail, will be of some utility both for pupils and practitioners.

A. R.

PARIS, *Nov.* 1, 1865.



## SURGICAL CLINIC OF LA CHARITÉ.



GENTLEMEN : —

I am about to present to you, as I am accustomed to do at this period, a statistical *résumé* of the cases observed in this Hospital during the past year. It is right that you should know how long and difficult is the labor which serves as a basis to these lessons ; this will put you upon your guard against the possible errors of improvised statistics, by showing you what care and what attention the search for truth always demands.

The externes of the service are charged with collecting all their observations ; at the end of the month they are reviewed and collated under my inspection, and entered into a book which encloses each day, the list of those entering and those leaving the hospital. At the end of the



year, the internes read over each observation in order to condense into one line the principal facts, and arrange the tables of which the whole form a general statistic, which can always be controlled by the aid of the particular facts.

The service comprises 75 beds ; the number of patients observed rises this year to 1155. This number seldom varies ; last year it was 1114, once it was 1400, at another time, 950.

In short, it is nearly a thousand each year, and during the thirty years I have collected these statistics, I have reached quite a large total, which may be of real value. This explains to you why I demand such a rigorous execution of this work.

These 1155 cases are thus divided according to sex :

Males, . . . . .	797
Females, . . . . .	358

This is an almost constant proportion, perhaps a little exaggerated this year. In this there is nothing surprising. You know that men, by reason of their occupations, are much more

exposed to surgical affections than women. Added to this, the latter more generally dread a sojourn in the hospital; many apply only at the last extremity.

259 patients have been only transient, that is to say, entering at night, they have departed in the morning, without having been treated; perhaps because a slight affection or an incurable disease has not permitted their stay in the hospital. Of this number there were 174 males and 85 females.

There then remain 896 cases to occupy our attention: 523 males and 373 females. The proportion, as you observe, remains sensibly the same.

#### Terminations:—

Cured, . . .	681 = 489 males . . .	191 females.
Benefited, . .	102 = 66 " . . .	36 "
Without change,	59 = 32 " . . .	27 "
Dead, . . . .	56 = 34 " . . .	22 "

A certain number of patients leaving benefited, might have been classed in the first category, because they were in progress of cure; it was only a question of time. In regard to the dead,

the proportion is relatively considerable. It is about 1 in 11, whilst generally it is 1 in 15, sometimes 1 in 20.

Let us enter now into detail, and pass in review the different groups of disease. As you will see, inflammations come in for a considerable share, — more than half. We will commence with affections of the bones.

## FRACTURES.

These constitute a numerous group. Every year there are nearly a hundred. This year we count up 95, — 75 males, 20 females. The reason of this disproportion is that already given, exaggerated more in this particular group.

Of 95 patients, 80 went out completely cured ; 10 with a callous imperfectly consolidated, but in good condition ; 5 died. This last figure is small, and yet it was not in consequence of the injury to the bones that the patients have succumbed, but rather from the lesions of important organs injured concurrently.

*Bones of the head and trunk.* — Thus two patients with fracture of the cranium have succumbed, without any displacement of the bones having contributed to the result. One of them had a fracture of the petrous portion of both



temporal bones, parallel to their axes; the fissure commenced at the junction of the right parietal bone; it was not a fracture by *contre-coup*.

Equally in fractures of the vertebral column of which we have three examples, the fragments may act directly upon the marrow, tear it, crush it; but there can be, without that, concussion, contusion of the nervous substance. There results from all these disorders a paralysis of as much greater extent as the seat of the lesion is higher up; ordinarily, it is a paraplegia.

Death may happen very quickly by a generalization of the *méningo-myélite*, generally the inflammation remaining local. At the end of a longer or shorter period, the paraplegia persisting, comes on retention of urine, vesical catarrh, bed-sores; finally, marasmus, and a fatal termination.

Such, gentlemen, are the phenomena commonly spoken of regarding fractures of the spine in the dorsal region. Nevertheless, two of our patients affected with this lesion, have been dismissed, cured; at least, they can walk and accomplish all their functions, although disabled;

that is to say, they carry about a curvature in place of a fracture. As for the third, who died, he was injured in the region of the cervical vertebra. In short, the gravity of fractures of the spinal column has been perhaps exaggerated, at least as regards the dorsal region.

The treatment has consisted simply in the horizontal position, the patient being laid upon the back, the head deprived of pillows, a little lower than the axis of the body.

We have had only one case of fracture of the Lower Jaw. It got well without any bandage. Unless there are very great displacements, and difficulty in maintaining them reduced, I abstain from applying any. The pain of the injury is amply sufficient to prevent the patient from making any injurious movements, and the consolidation is effected regularly, without the patient being condemned to an immobility which is in itself a real hardship.

Fractures of the *ribs* amount to 19. Their treatment also demands a reform. If you should read the articles recorded by different authors,

you would be frightened by the gravity attributed to these fractures. The truth is the same as for those of the cranium; it is by the crush, the wounds of the thoracic viscera, that death often happens.

As to simple fractures of the ribs, they generally cure themselves; pain is the only symptom to which it is necessary to address any remedy. Nevertheless, what machines have been imagined! J. L. Petit, Duverney, Boyer, have each his own. Lisfranc invented placing upon the sternum on one side, upon the spine on the other, mountains of compresses, tightening the whole by aid of a bandage, in a way to crush the patient from before, backwards, in order to make the costal arch spring outwards! A simple bandage round the body, maintained fifteen days, brings about the cure.

*Inferior members.* — Fractures of the Pelvis are among those, which the neighborhood of important organs renders dangerous; a single case terminated by death.

It is necessary to add to this two cases of fracture of the acetabulum.

In regard to the femur, five cases were of the shaft, six of the neck.

You have doubtless heard of innumerable machines invented for treatment of fractures of the thigh, all having for their object continuous extension, designed to oppose shortening. Let us look at the means I employ. I leave the patient laid upon the back, the thigh extended, the ham lightly flexed upon a pillow. A crupper, round towel, embraces the ischium, and is fixed at the head of the bed for counter extension. A stirrup-bandage at the level of the malleoli, allows the fixing of two tapes attached to the foot of the bed for extension.

With this apparatus, easily comprehended and applied, easy to find and to fabricate, you obtain a cure, with two or three centimètres of shortening, and not fatiguing the patient in the least.

Now a long time ago, I made the remark that this slight shortening is not an inconvenience, and *never causes lameness*. We have had even



this year, two or three examples of patients having old fractures, and not limping, in spite of shortenings reaching sometimes three centimètres. There is produced little by little, an inclination, a twisting of the pelvis, which soon remedies limping.

The latter is, on the contrary, often occasioned by those beautiful apparatuses and complicated bandages, which may bring about either sloughs or swellings, from the restraint of the neighboring articulations. Lameness is, note it well, much oftener the consequence of stiffness of the joints, than shortening of the limb.

For the Leg, the cases are divided thus : —

Leg, both bones, . . . - . . . . .	8
Tibia, . . . . .	4
Internal Malleolus, . . . . .	3
Both Malleoli, . . . . .	3
Lower extremity of Fibula, . . . . .	6
—	
Total, . . . . .	24

For fractures of both bones, commonly called fractures of the leg, an apparatus for extension is also demanded, and a powerful one, to wrestle

against the muscular masses of the calf of the leg. The truth is, that these machines, ingenious as they may be, are powerless to prevent shortening. However, as we have seen, this is of little importance.

On this point I call to mind a patient whose leg was broken by a gunshot wound in 1848; it was decided to preserve the limb. The cure was brought about with a shortening of five centimètres. Although the subject limped for a long time, all lameness has now disappeared. What mechanical contrivances would not have been needed to oppose such a retraction? A simple immovable bandage, a dextrine bandage, sufficed for consolidation.

In regard to fractures at the malleoli, which, from the respective position of the two bones, are not generally accompanied with any displacement, the same bandage accomplishes the cure in three weeks.

You see then, gentlemen, how simple the treatment of fractures of the lower limbs may be, and how urgent it is to disembarass ourselves of

all that gear, which is so tedious for the surgeon to apply, so painful for the patient to bear, and profitless to everybody.

Finally, the *knee-pan* is often simply broken across. The *kiastre*, a bandage for uniting cross wounds, is sufficient to bring about a fibrous callous which permits the use of the limb; here also it is, above all, necessary to avoid the stiffness occasioned by too tight applications.

*Upper Extremity.*—The clavicle sums up only four cases. This number is a little less than that of preceding years. Contrary to what was formerly believed, this fracture is quickly consolidated; fifteen to twenty days suffices. Know also, that it is impossible to cure it without deformity. This will explain to you the hundreds of appliances already invented against it, without counting those held in the womb of futurity. The important point is that this deformity does not injure the functions of the limb. It is sufficient, at the end of four or five days, to apply an immovable apparatus, fixing the hand of the injured side upon the opposite shoulder. Take it

away at the end of fifteen days; the union is already solid.

We have one case of fracture of the *scapula*. Note it well, there is no apparatus to be applied; the cure is made without any.

There are six cases of fracture of the *humerus*; three of the shaft, three of the neck.

For those of the neck of the humerus, anatomical or surgical, the treatment is most simple. It consists, the displacement being reduced, in maintaining the limb fixed against the side of the chest, and parallel to its axis. But never neglect to interpose between the arm and the thorax, pads of wadding, without which you will run the risk of seeing inflammation and suppuration brought about by the contact of the naked flesh.

These fractures of the anatomical neck have also shown that, contrary to the general belief, they unite well. Although the head may be somewhat a foreign body, nevertheless consolidation is effected as in other cases.

The fractures of the *shaft* of the humerus de-



mand for their support, a roller and splints. These fractures are those most liable to non-consolidation, to false joints. This appears strange at first sight, nevertheless, gentlemen, never hesitate to admit a demonstrated fact, convinced that sooner or later, the explanation will be found.

Here it is easy to be given. You have a single bone in the midst of muscles situated between extremely movable parts, the scapula and the fore-arm. It preserves then, in spite of appliances, an extreme tendency to make slight movements which are enough to interfere with the union. Thus it is necessary to be a little more watchful.\*

These are the number of Fractures of the Fore-arm : —

Both bones, . . . . .	2
Olecranon, . . . . .	1
Shaft of the Ulna, . . . . .	1
Of the Radius, . . . . .	1
Lower extremity of the Radius, . . . . .	11
Total, . . . . .	<u>16</u>

\*It is best to treat such fractures by an angular splint, in order to avoid motion of the fragments, which even a slight movement of the elbow would cause. — W. C. B. F.

The fractures of the fore-arm proper, both bones at once, have shown us that they are grave and demand great attention. The ulna and the radius by their form and position, tend on one part, to project backwards, where in consequence of the adherence of some muscles to the osseous prominences of the elbow, they bring about an irremediable hindrance to certain movements of the arm.

On the other part there is a great tendency of the two bones to approach each other and to efface the interosseous space, whence results the more or less complete abolition of the movements of pronation. If there is too great compression, it interferes with the course of the circulation of the blood in the arm, to the great injury of the patient.

It is in the fore-arm that we most often see gangrene in consequence of too tight bandages, fruitful source of prosecutions against physicians. It has been said that these fractures are almost as dangerous to the surgeon as to the patient. Watch, then, with double care.

Once more, we have seen, by one case of fracture of the *olecranon*, that it is a lesion of little importance. A figure of 8 bandage—a roller, suffices for the cure, because it is not in the least necessary to obtain a union of the fragments.

You know in truth, that with many kinds of animals, the *olecranon* is free and analagous to the patella, without interfering with or hindering the functions of the limb. Just so with man, all that can result from this fracture is an obstacle to the perfect extension of the fore-arm upon the arm. Now this is a position which is not indispensable. Guard then, above all, against the formation of sloughs, and be contented with the formation of an indurated fibrous tissue, which suffices perfectly for the re-establishment of the functions of the limb; this arrives at the end of a month or six weeks.\*

\* Perhaps M. Velpeau dismisses this fracture too cavalierly. The arm being nearly straight, the fragment of bone is to be approached as closely as possible to the part from which it was separated. It is retained there by strips of adhesive plaster, perhaps a little compress of lint being placed upon the fragment. Then the figure of 8 bandage is applied, and a gutta-percha splint lined with lint or cotton flannel, moulded upon the front of the arm,

The fracture of the *ulna* alone, is easier to cure than that of both bones, although by reason of its situation it tends to project backwards and inwards; as it is together with that, very movable at its inferior articulation, you run the risk of obtaining a bad union, hence once again the application of an immovable bandage ought to be made with all due care.

Fractures of the shaft of the *radius* give occasion for remarks of the same kind.

Those of the lower extremity of the radius have taken, as you all know, the place of dislocations of the wrist, which are now scarcely spoken of except for remembrance. They are recognized from a distance by a particular Z-like appearance, like the heel of a silver fork; the carpus projects backwards, with a depression above it; in front it is the reverse, depression at the carpus, projection above it. Joined to reaching from half way above to half way below the elbow. A bandage confines this to the arm. The whole should be removed in a fortnight. The use of the limb should then be resumed, and the little stiffness that has resulted will soon disappear.

W. C. B. F.



that, a slight flexion of the hand, a little twisting at the same time towards the ulna, and you will never be deceived. That is pathognomonic, in this sense, that no lesion of the wrist (unless an old affection) is accompanied with a like deformity ; only the converse of this proposition is not true ; a fracture of the radius can exist without this deformity.

In regard to prognosis, they are seldom dangerous. Left to themselves, they get well without notable alteration in the functions of the limb ; the fragments can even in consequence of their impaction, get well without any bandage.

Only there results a deformity. Treatment, then, is only a luxury. But, gentlemen, surgery often aims at remedying simple deformities, and it should be done whenever no danger shall result to the patient.

Unhappily, here, this is very difficult and even dangerous. The bandage, as we have seen in fractures of both bones, exposes the patient to sloughs, to compressions, to articular stiffness, &c. Read the clinic of Dupuytren and you will

see that after the application of his apparatus, — his pistol splint, — the patients have dragged out four or five months in the wards, with incomplete anchyloses, — with stiffness impossible to overcome.

Thus I have renounced for a long time, all these bandages, more or less complex, and have confined myself to an apparatus which partly lessens the deformity, and that without danger, inasmuch as it permits the fingers to recover their suppleness at the end of one or two months.

I derived the principle of it from a letter written to me by a Danish surgeon, whose name has escaped me. He placed the fore-arm upon a thick pad, so that the hand lay beyond it from the wrist, flexed by its own proper weight, and at the end of a suitable time many successes were obtained.

The proceeding appeared to me ingenious, but a little troublesome for the patient. I have modified it thus: At first, I obtain immediately, the required position, by very strongly flex-

ing the hand upon the fore-arm at a right angle ; the extensor tendons thus constitute a pulley to push back the fragments. The limb is then fixed in this situation ; a dry roller, a graduated compress upon the back of the fore-arm and the hand, a splint of moistened pasteboard, which moulds itself perfectly, a dextrine bandage maintains the whole.

The important point is to be watchful that the hand is not straightened till the dextrine dries ; you guard against that by fixing the parts with tapes for five or six hours. I am generally well pleased with this apparatus.

## AFFECTIONS OF THE JOINTS.

They number 79, thus distributed : —

Dislocations, . . . . .	8
Sprains, . . . . .	17
Inflammation of the Joints, . . . . .	45
Dropsy of the Joints, . . . . .	9

We can study at the same time, the affections of the bursæ and the sheaths of the tendons, to the number of 13.

*Dislocations.* — Their number is inconsiderable, but it is nearly the normal average; the figures of the three last years have been 6, 8, and 12.

However, this limited number is perfectly in proportion with the other statistics; in 8 cases observed, there were 7 males and 1 female; 6 dislocations of the shoulder, 2 of the elbow. The dislocations which complicate fractures of



the fibula are not comprised in this list, nor those of which the treatment did not demand the admission of the patient to the hospital. Such were two dislocations, one of the finger, and one of the thumb.

As usual, the shoulder has furnished the largest quota. You know very well how complex and obscure the classification of these dislocations has become. For myself, I admit only two great classes; dislocations outward and backward, or *postero-externes*: dislocations forward and inward, or, *antero-internes*.

In regard to the first, there is no dispute; let them be called subspinous, or, subacromial; everybody admits that these are only degrees of difference. Now, it is just the same for dislocations inwards. In a general way there is only one, nevertheless the varieties have been multiplied beyond measure. Thus, dislocations downwards, or, sub-glenoid, the sub-coracoid, the intra-coracoid, the sub-clavicular. Larrey created the intra-costal. Remember only this remark, these different names are applied only

to shades of difference ; among other things, the true dislocation downwards is not possible.

This has not prevented it, admitted since the earliest ages, from acknowledgment through every epoch, even that of J. L. Petit and of Duverney ; created by the imagination alone, nobody before our day had dreamed of proving its existence. Now, not an example of it has been found, and moreover it is acknowledged to be impossible. If the humeral head can put itself in contact with the side of the scapula, below the glenoid cavity, it will be produced by an abduction which carries the arm upwards, and in order that the dislocation shall exist, it must be maintained there ; this, the weight and the long tendon of the triceps renders doubly impossible.

Nevertheless, subterfuges have been found, and the name of dislocation downwards, or subglenoid, has continued attached to the displacement in which the head of the bone is situated at the *lower part of the internal border* of the glenoid cavity ; thus you see it is a dislocation inwards.

For myself, these shades of difference are reduced to two, according to the position of the head of the bone in the midst of the muscles. Most frequently you find it under the sub-scapular muscle; it is the *sub-scapular* dislocation. When it projects into the axilla it is covered by the pectoral muscles, hence I have given it the name of *sub-pectoral* dislocation.\*

All these dislocations have been reduced by horizontal traction — the ancient method. Perpendicular traction from below upwards, is sometimes preferable for the sub-pectoral variety.

Two dislocations of the *elbow* presented themselves; very remarkably, one of them was forwards and without fracture, but strongly carried to one side; it was, properly speaking, a dislo-

\*Here it will aid the reader to recognize in this maze some of the dislocations of the shoulder and their classifications:

The *sub-scapular* dislocation of M. Velpeau corresponds to the *sub-coracoid* of M. M. Malgaigne and Nelaton.

The *sub-pectoral* corresponds to the *intra-coracoid* and the *sub-glenoid* of the same authors, according as the head is situated higher or lower.

All admit a *sub-clavicular* dislocation, although extremely rare.

A. R.

cation forwards and outwards. Both were reduced.

*Sprains.* — We have had 17 to treat ; most of them were only transient. All have been cured, and without consecutive accidents.

Remember this, for it is like fracture of the ribs. It has entered the heads of some practitioners that a sprain is a dangerous lesion, demanding serious care. Baudens even published, in his time, a memoir *apropos* of a particular treatment, and he cites not less than 12 cases of cure !

Then the rubbers with their manœuvres, their manner of procedure, have contributed still more to frighten the public, without counting the accidents which they themselves have caused. Meantime, something has come of it ; it is acknowledged that by the aid of a certain cham-pooing the patients are rid of their sprain more quickly. It is a real fact which some practitioners have known how to improve. The explanation, whatever it may be, is not yet found ; perhaps something analagous to the phenomena



which follow the crushing of tumors containing blood takes place. It is a question to return to and to study.

A sprain is a slight affection which brings about neither an inflammation of the joint nor white swelling, unless in cases altogether exceptional; it is cured by the use of resolvents and compression, and in a sufficiently short time.

*Inflammation of the Joints.* — There are 45 cases. In regard to treatment, they have shown us the efficacy of the two following methods: — large flying blisters applied successively round the joint, and entire prevention of motion by the aid of immovable bandages.

I prefer this to a movable apparatus for two reasons: first, because patients can rise from their beds, secondly, because the limb once in the mould, only movements of the whole are possible, the joint remaining motionless. To obtain this it is necessary that the bandage must be properly applied, and above all is of sufficient extent; thus, for the knee, the most frequent seat of chronic inflammation, it is necessary that

the foot, the leg, and the thigh, to a sufficient height, must be confined, so that all movements are prevented and all the members condemned to a complete immobility. The first effect of the bandage is to relieve the patient very much, and that on the next day. Resolution is obtained, and in from fifteen days to three weeks, the cure is more or less complete.

*Dropsy of the Joints.* — We have had 9, nearly all of the knee. Besides blisters, resolvent friction, there is a mode of treatment for you to notice; the injection of iodine. It has been practised four times. Furthermore, three patients thus treated, are not included in the statistics because they had not been discharged on the first of August; two are still within the wards, and in a promising condition. Here, then, are seven cases of puncture with injection of iodine into dropsical joints, which you have witnessed. This is sufficient to prove to you the following points: —

1st. These injections are not dangerous, and it is an important fact, because the fear of grave

accidents has been the greatest obstacle to their introduction into practice.

2d. They do not prevent the employment of other modes of external or internal treatment, such as resolvent ointments, blisters, &c.

3d. They have an undoubted efficacy, since, with all these patients, a cure was effected; that is to say, the pains were dissipated and the functions of the limb restored.

4th. Finally, these injections never cause ankyloses; I have never seen it produced, and yet I have practised it upon a great number.

Do not hence conclude that it is an infallible method. The truth is, the patients are benefited in most cases, and a certain number of them are radically cured.\*

*Affections of the Bursæ and Sheaths of the Tendons.* — These naturally find their place by the side of the effusions. We have had 13 examples; there is not much to say of them. Effu-

\* The operation is very simple, and analogous to that for hydrocele. M. Velpeau uses a liquid composed of equal parts of water and tincture of iodine.—A. R.

sions of all kinds, pus, blood, serum, inflammations and contusions have been observed in turn. Let us see what practical points can be gained from the study of these 13 cases.

*Effusions* of an *inflammatory character*, purulent and sero-purulent, *sanguine effusions* have all been treated by the same method; a more or less large puncture with the bistoury, — detersive injections. For *serous collections*, the iodine injection, after attempting to procure resolution by flying blisters and topical applications, such as mercurial frictions, ointments of the iodide of lead, &c.

The iodine injection has been employed this year in two exceptional cases; thus, one patient had a cyst in the neighborhood of the tibio-tarsal articulation, which troubled me because I feared a communication with the joint. I injected it, however, which I should not have dared to have done formerly, before the innocence of it had been proved to me.

There was an analagous case which put me upon the track. Having injected a cyst in the



popliteal space, I perceived the next morning, to my great alarm, that the liquid had entered the joint; the patient was cured. Thenceforward, together with M. Bonnet, of Lyons, I began to practice the injection of iodine into joints.

The second case relates to a young man who had a tendinous dropsy of the wrist (weeping sinew). He got well by injection, but not so rapidly as the first case, because the synovial membrane was covered with granulations which yet remain.

## INFLAMMATIONS OF THE CELLULAR TISSUE AND ABSCESES.

Here let us observe the inflammation of the cellular tissue alone, and more particularly of that cellular tissue disposed in layers, and not of that which enters into the structure of almost all the organs by more or less delicate lamellæ.

This section comprises not less than 181 cases ; a number relatively large compared with that of former years. You know that no affection is more frequent than inflammation ; it embraces more than two thirds of pathology, particularly surgical pathology.

In addition to which, if we unite under the same title, as you will see further on, whitlows, carbuncles, and boils, it is because these are only varieties which derive their particular characteristics solely from their situation.

The cases are divided thus :—

Phlegmons and Abscesses, . . . . .	133
Whitlows, . . . . .	39
Carbuncles, . . . . .	7
Boils, . . . . .	2
	—
Total, . . . . .	181

*Phlegmons and Abscesses.*— We will attend first, among other things, to the examination of abscesses according to their situation. They are thus distributed in this connection :—

Head and neck, . . . . .	23
Trunk, . . . . .	8
Arm and fore-arm, . . . . .	8
Hand, . . . . .	24
Lower limb, . . . . .	50

and each region furnishes facts, particular indications. Because, gentlemen, if it is well to generalize in theory, it is above all well to particularize in application. Affections vary not only according to individuals, but according to situation.

It is thus that *inflammation beneath the scalp* often occasions the greatest disorder. One of my patients had all the skin of the cranium loos-

ened and shaking upon his head like a cap; by good luck he recovered.

In the *cheek*, on the contrary, not at the chin, but in the zygomatic portion, properly so called, in the neighborhood of the superior maxillary, you have the type of localized phlegmon.

To what do these differences belong? To the lamella-like nature of the tissue which separates the skin of the cranium from the aponeurosis, whilst in the cheek it is tightly packed between the muscles and the bones. These are purely anatomical facts.

In the *supra-hyoidean region* nearly all abscesses have their origin in a gland, hence the suppuration is circumscribed, as we shall see immediately when treating of Adenites.

In the *lips*, where the muscles, the cellular tissue and the vessels are so delicate and so interwoven, that a true, homogeneous, felt-like web, with fine meshes is formed, you equally observe inflammations to be circumscribed, strangulated, so to speak, the abscess taking the character of a boil.



Thus the lamella-like, cellular tissue, with large meshes, favors diffuse inflammation, and is almost a *sine-qua-non* of its formation; opposite conditions give rise to circumscribed inflammation. Now in these two cases, as you well know, not only is the treatment different but the danger is not comparable.

Whilst diffuse inflammation spreads over a large surface, loosening the skin, dissecting the vessels and the nerves, often leaving behind it incurable disorders, circumscribed inflammation remains limited to a small space, only exceptionally producing mortification, and commonly leaving after it no serious trace.

Further, the march of diffuse inflammation is essentially rapid; in four days, rarely more, suppuration arrives, which is delayed for at least eight days in circumscribed inflammation.

The deduction is simple. You should never attempt to disperse a diffuse inflammation after the fourth day; you may be sure that pus has formed, and that there is no ointment which can

disperse it. There is only one thing to do ; cut down freely in many points.

If, on the contrary, the question is one concerning circumscribed inflammation, even at the fourth or fifth day, you can attempt and perhaps obtain resolution by means of leeches, flying blisters, and mercurial ointments. It is by virtue of these principles, and always taking the anatomy of the region into consideration, that our patients have been treated.

*Phlegmons of the Hand.* — In this general group, inflammations of the hand merit a distinct place. There have been 24 cases, of which 8 were females. The *palm* of the hand is most often attacked ; almost always, at least, it is the part in which it commences.

Now we distinguish, as you well know, the hand on the palmar surface, into the region of the *thenar* eminence, the *hypothenar*, and the palm of the hand proper. At the *thenar* eminence, inflammation takes on the diffuse character readily, because there is beneath the skin a loose tissue which is continued to the thumb ;

thus this inflammation is often complicated with whitlow. At the hypothenar eminence, there is the same disposition to the same phenomena.

In the palm of the hand it is different altogether; the sub-cutaneous layer of cellular tissue is very thin, very tough; it is a close web, between the aponeurosis and the skin; hence inflammation of it can only be circumscribed.

If, on the contrary, it springs beneath the palmar fascia, it finds itself in the synovial sheaths of the region which communicate in one direction with the fingers, in another with the fore-arm. Hence the intensity of the pain, and of the general phenomena which, combined with the extension of the disease, may carry off the patient.

These inflammations of the palm of the hand arise most frequently near the articulations of the meta-carpus with the phalanges, beneath the epidermic indurations which laborers call *calloses*. Inflammation once commenced, crowds between the indurated skin and the palmar-fascia, which resists it, passes across the commis-

sure of the fingers, and reaches the back of the hand.

Here the conditions are altogether changed; in place of the close tissue of the palmar surface, a loose texture extends over all the back of the hand and fingers; here the pus appears. Hence I am in the habit of making, even in these cases, the incision in front; I almost always find the source of trouble beneath the callous. This is the result of a precise anatomical knowledge.

Recollect, also, that a large opening made at the commencement, prevents all these disorders, and the loosening of the skin on the back of the hand and fingers.

*Felon.* — This word has the privilege of scaring the patient, and frequently the doctor. Nevertheless it is an inflammation, like any other, without special characteristics, except those belonging to its region. We have had 39 — 30 males, 9 females. The statistics of the four last years give me a total of 108 cases — 83 males, 25 females.

You see that the proportion is not a minimum



for the latter ; on account of labor with the needle which exposes them to pricks, and as a sequence, to inflammation of the finger.

Of the 39 cases this year there are

Of the fore-finger, . . . . .	13
Thumb, . . . . .	15
Middle-finger, . . . . .	5
Ring-finger, . . . . .	4
Little-finger, . . . . .	2

This is altogether in conformity with what might have been predicted. In the same way the right hand is more often attacked than the left.

In regard to species, I have established four, which are based solely upon the anatomical disposition of the parts ; thus based, it does not appear to me that they can be disputed.

1st. The whitlow beneath the skin, or the sub-epidermic whitlow manifests itself by a vesicle, oftenest at the root of the nail, constituting a run-round. It is of little consequence, and gets well of itself. It is better to open it and cut away the dead skin.

2d. The sub-cutaneous whitlow, properly

called, arises in the cellular tissue, between the skin and the fibro-synovial sheaths. In the last phalanges of the fingers where these sheaths do not exist, it rapidly takes on the characteristics of profound or periosteal whitlow, whence the danger of necrosis of the phalanx and the necessity of speedy treatment.\* In the thumb and in the little finger the inflammation can reach the thenar and hypo-thenar eminences, on account of the relative laxity of the cellular tissue. We have already noted the possibility of the converse phenomena.

3d. The fibro-synovial whitlow is ushered in by extremely severe pain. It extends rapidly, by means of the synovial sheaths, gains the palm of the hand, and can even, passing the annular ligament of the wrist, reach the fore-arm. If it suppurates, there must necessarily result from it a hindrance of function, an obstacle to the move-

\* This should consist in early, free incision, and if the probe detects dead bone this should be removed by forceps; thus leaving the nail and a useful finger.

ments of the hand and of the fingers, from the restraint to and stiffness of the flexor muscles.

4th. The periosteal or profound whitlow almost inevitably causes the death of the phalanx; happily it is very rare, unless at the end of the fingers, as we have just said.

An early incision is necessarily only indicated in the fibro-synovial whitlow. It is absolutely necessary to prevent suppuration, for the reasons given above. In the other varieties you may wait the formation of pus.

*Carbuncle.* — We have had 7 examples; 4 males, 3 females; —beside 2 boils. All got well, at least of the local trouble, for one of the patients died of erysipelas contracted in the wards.

I treat carbuncle by a method peculiar to myself; at least, according to certain rules I have established. At the start, whatever anybody may say, an incision is the best treatment; it is commonly made crucial. This is insufficient.

I make a radiated incision; the tumor having generally a circular form, I cut it according to its different diameters, so that it will present to

you the appearance of a cart-wheel. Furthermore, all these spokes which converge towards the centre, should be separated at their base by an interval of one or two centimetres, *at most*, and *pass a little beyond the circumference of the tumor*, trenching upon the sound tissues.

In this way only, can you surely arrest the inflammation. If you believe that carbuncle is sometimes sufficient to produce death, you will not hesitate to employ a proceeding whose efficacy amply redeems its apparant barbarity.\*

\* The late Mr. Ledwich, of Dublin, in his exhaustive paper on Carbuncle, published in the *Dublin Journal*, 1856, recommends in cases of large anthrax, plugging the long incisions with lint soaked with spirits of turpentine, as the knife passes along, thus preventing bleeding, which might prove fatal to an aged or feeble patient.

A short time ago Prof. H. J. Bigelow made a public protest against shallow incisions in anthrax. Dr. Collis, of Dublin, says that the cut should be deep enough to allow the flaps to be lifted by forceps. — W. C. B. F.



## DISEASES OF THE LYMPHATIC SYSTEM.

We shall here occupy ourselves only with acute affections, and you know that these are not the most numerous; but the engorgements, the chronic adenites do not generally require the sojourn of the patients in the hospital, unless it is in hospitals for specialities.

*Inflammation of the Lymphatic Vessels.* — We have 13 cases, so far as distinct affections are concerned, without counting those which have appeared as a complication. Of this number, 11 were males, and 2 females; always the same proportion with the same cause.

This inflammation of lymphatics opens the door to the interpretation of many other affections; you will see here only those called external, surgical. But there are internal affections

of the lymphatics, belonging to the department of medicine. Reflect a little upon its mechanism; it almost always begins with a prick, a scratch upon the fingers, upon the foot; then the redness appears, spreads, mounts the fore-arm, the leg, &c. If it is in the deep lymphatics you follow in imagination an analagous phenomenon. Look at the interior; in the mouth it is again manifested. A scratch, a dental caries, and you will see rapidly appear a lymphatic inflammation, a swelling of the glands, often terminated by suppuration.

But in the œsophagus, the larynx, the intestines, you see nothing; nevertheless do you doubt that analagous lesions may be produced there? There are certain maladies characterized by pustules, ulcerations of the intestines; is it not clear that some irritating atoms can pass from thence into the lymphatics which open there, and thus infect the whole economy? Some light can thus be thrown upon a certain number of facts in the department of internal pathology.

Mark, moreover, that it is not necessary that

a morbid atom shall inflame the vessel in passing through it, to cause the inflammation of a gland. Yet if the latter is limited to the internal wall of the duct, as can sometimes be recognized, there is nothing apparent externally, and yet the disease does not the less exist.

An important point is to isolate inflammation of the lymphatics from affections with which it may be confounded, above all, from *erysipelas*. You will understand the interest of this study, if I tell you that there are yet meritorious practitioners who do not distinguish them.

This is owing to a confusion maintained from the first. It is always so in the history of the human mind; whilst one tries to cast light upon a fact, another seeks to hide it under a bushel. So formerly, whilst I tried to distinguish inflammation of the lymphatics from *erysipelas* and *phlebitis*, Blandin attempted to demonstrate the identity of the two first affections; and as there was something specious in it, minds were captivated. Some still hold this idea.

Now, if it is true that lymphatic inflammations

are often complicated with each other, they also exist separately. They form two maladies of very different severity, erysipelas being extremely dangerous, whilst lymphatic inflammation is scarcely so at all. Let us then study the distinctive characters.

Erysipelas kills as a general disease, lymphatic inflammation as a local disease. The former often commences without wound or excoriation, the latter, never; lymphatic inflammation shows itself in filaments or patches, which pass from one place to another, always following the axis of the limb; erysipelas spreads itself out in sheets, lengthways, crossways, in fact, every way. Lymphatic inflammation never leaves the point of origin except slowly, when the redness has reached the axilla, for example, it still persists in the fingers where it commenced. The part where erysipelas commences is ordinarily healed when the affection has attacked parts further along. Lymphatic inflammation is often terminated by abscess; erysipelas, never,



unless it becomes phlegmonous, which is a complication.

Finally, the treatment also differs, in this manner, that it does not stop erysipelas, whilst a proper medication may put an end to lymphatic inflammation. All sorts of topical applications, and even sometimes cleanliness, produces satisfactory results. We employ, above all, resolvent ointments, mercurial frictions, flying blisters, leeches and compression.

Lymphatic inflammation ought also to be distinguished from diffuse inflammation. The latter presents itself under the form of a sheet-like inflammation with a central point, which soon presents signs of approaching suppuration; lymphatic inflammation, when it is not net-like, is constituted by separate patches, or united by little tracks or stains less red. Still again, it differs in this point, that suppuration in diffuse inflammation is not delayed more than four days; then you draw out by incision, thread-like wads of mortified cellular tissue; whilst each knot of lymphatic inflammation takes from eight

to ten days to furnish pus, and then always in a less quantity than you would expect.

In regard to *phlebitis*, I will give you in two words, a distinctive characteristic. It is *felt*, it is perceived by the touch, as an indurated cord; lymphatic inflammation is *seen*. Here is an element sufficient to put you upon the track. Meantime you ought to study it in detail.

*Glandular inflammation*. — There have been 38 cases — 28 males, 10 females. I have published an article upon them in the new *Dictionnaire Encyclopédique*, and I do not wish to enlarge upon the subject at the present time.

Only, notice this important point; acute inflammations of the lesser glands, such as those of the groin, and of the axilla, are comparable to those of the larger, and to those of the breast in particular. They give rise to three varieties, according as they are *sub-cutaneous*, *parenchymatous*, or *deep*.

Moreover, abscess oftenest begins in the parenchyma, and may remain confined to it. If it issues thence, the two other varieties present

themselves, according as the pus makes its appearance between the gland and skin, or beneath the fascia.

For sub-cutaneous abscesses incision is easily practised, and with great service. For deep abscesses it is more troublesome, since it is difficult to recognize fluctuation, and the presence of the great vascular trunks often arrests the surgeon's hand; it is necessary to wait.\*

*Erysipelas.* — Erysipelas has been this year a real scourge. We have had 35 cases, of which 21 were traumatic; 15 died.

It is a frightful number. During the whole of my thirty years I have had only 200 cases; I have passed ten, fifteen months, without seeing an example. All surgeons say the same; but

\* In cases of deep or profound abscesses, Mr. Hilton's method of opening them is probably the safest and best. It is accomplished by cutting through the skin and sub-cutaneous tissue, and then plunging the points of a common pair of dressing forceps through the fascia to any depth necessary. Then opening the handles widely the tissues are torn apart. This sort of opening does not close as quickly as a clean cut, and no blood vessels are likely to be injured. — W. C. B. F.

then erysipelas has become more and more frequent and of greater severity, a fact which should be placed on record. As to the explanation, it is not yet found.

Moreover, I have tried all means without preventing it any, and only making me doubt their efficacy. I am convinced that none of the known methods of treatment, either local or general, can triumph over it.

Nevertheless, there are more lucky persons. Each year at least, an efficacious remedy is boasted of, and generally it is from the country that it comes to us. The fact cannot be contested; it proves simply that the disorder is less dangerous down there than in our hospitals or in our city.

Thus a doctor of Caen, Dr. Lebidois, cures *all* erysipelases with tincture of aconite, in a dose of six, eight, and ten grammes. I have tried it without any result. You can moderate, regulate the march of the disorder; to stop it short is as yet impossible.

What is of the highest importance is to thor-



oughly recognize erysipelas, and to distinguish it from lymphatic inflammation; I have tried, further back, to show you the way to do so, permit me to dwell upon it a little longer still.

Erysipelas has in truth, certain pathognomonic signs upon which I wish to direct your fixed attention. At first, there is upon the outer limits of the disease a red, *festooned border*, slightly in *relief*, so that you can perceive it by lightly passing your finger over it. Outside this border, the tissues are perfectly sound, and this is the more remarkable, since it is at the edge of this border that the redness is most marked. It augments in intensity *from the centre to the circumference*; this is pathognomonic.

Moreover, all other inflammations are accompanied with a more or less considerable tumefaction of the sub-cutaneous tissue; in this, nothing of the sort, except upon the head, if it mixes itself with lymphatic inflammation. It is a sheet of inflammation which spreads itself out farther and farther along above the tissues whose deeper layers are not attacked. It is

something like the rising tide, which encroaches more and more upon the shore ; only, differing from the sea, it never ebbs.

Then, remember it well, although it may astonish you, erysipelas never lasts but *four days* upon the same place ; only, as the regions are successively invaded, the total duration may amount to six weeks ; ordinarily, eight to ten days. Thus, when I say four days, I mean, for a given patch, and sometimes you see only one, an infallible source of error for the inventors of new remedies.

I have told you that erysipelas never terminates by suppuration, and yet it is published as a fact, every day. It is that they have confounded it, that they have not known how to distinguish it from *phlegmonous* inflammation, which often declares itself beneath the erysipelatous surface, constituting *phlegmonous erysipelas*. But it is a complication, the same as you sometimes see common inflammation complicated with erysipelas, constituting then, *erysipelatous inflammation* ; two terms which are often con-

founded and misunderstood, but which I think you will be able to distinguish henceforward.

As to telling you how erysipelas kills, it is unknown; evidently the inflammation does not suffice to explain the fact. There is by it a true intoxication, by means of morbid atoms; a poisoning, the nature of which is not yet elucidated.

## BURNS AND CONTUSIONS.

These two affections, which at first sight seem so dissimilar, I nevertheless join together ; because you will see that in regard to the succession of phenomena, they have the greatest analogy, and what can be said of one may be equally applied to the other.

*Burns.* — We have had 25 ; in the three preceding years there were only 43 in all, so it is a relatively large number. During the thirty years, the entire total is 306 — 209 males, 97 females ; 23 deaths. This year the disproportion in sex is greater, since we have had only 4 cases of females, 21 males ; 4 deaths.

These burns have shown you that their danger depends on two things ; first, on the extent ; secondly, on the depth of the lesion. In regard to extent, it is on account of the breadth of the



burned surface, that we have lost our four patients; because, although a superficial burn is trivial when it does not exceed one or two square décimètres; it is so much the more dangerous when it invades a more considerable portion of the cutaneous surface; so that an individual only scorched, is nevertheless lost.

The explanation is simple; it is by the suppression of the functions of the skin that death happens. M. Fourcaut has made some remarkable experiments on this subject. He has found that by covering the body of an animal with an impermeable varnish, death infallibly takes place within twenty-four hours.

As to the *depth* of the burn, the consequences are very variable. Suppose a circumscribed lesion; if the epidermis only is attacked, the cure is rapid. If the dermis is compromised there is a slough. This must fall, then the hole which results from it must be filled. All this demands considerable time, and your remedies can only abridge the duration of it.

In regard to the treatment, you have seen that

burns of the first and second degree get well by all sorts of remedies, — cold water, resolvents, astringents, perchloride of iron, tannin, and above all, by the oil and lime-water liniment. This has moreover, the advantage that it is conveniently employed for certain parts, the face, for example, when other topical applications are difficult to keep in position.

These burns are advantageously modified also, by absorbent powders, flour, bismuth, *talc*, which we have tried this year, and which has offered nothing in particular, either good or bad, unless it is that it impregnates and soils all surrounding articles. They can be healed very well also by strips of sticking plaster, applied as for ulcers; two or three dressings are sufficient.

Burns with sloughs are treated like wounds; poultices, anti-septics, powdered bark, &c.

*Contusions.* — We count up 84 — 58 males, 26 females. They resemble burns, inasmuch as they present many analagous degrees. Thus, in the first degree, the skin is simply grazed; in the second, there is bloody *infiltration*; in the

third, there is bloody *effusion*. If there is a slough, which often happens, all goes along absolutely, as in a case of slough by a burn; and it cannot be otherwise, whatever the cause, from the moment that a flap of skin is mortified, the phenomena of expulsion are the same. Apply, then, to contusion with slough, what I have said concerning burns.

In regard to sanguine infiltrations and deposits, they demand distinct study; the progress, the prognostic, and the treatment are not the same.

Sanguine infiltration consists in a true imbuing of the tissues, by the nutritious liquid issuing from the vessels. It offers no danger when it is simple, and always heals even without treatment. Nevertheless, one ought not to abstain from it; it is certain that bleeding, if the individual is plethoric, resolvents, purgatives, &c., hasten absorption. Always then, have confidence, even in those frightful cases where a limb, like the thigh, for example, is doubled in size, that it will get well.

Your attention is further called to two facts, not sufficiently studied, in regard to sanguine infiltration.

The first is relative to anatomy. The liquid does not always follow, as you might think, the laws of gravity ; thus a contusion in the fold of the groin will produce an infiltration, which, in place of extending down the thigh, will mount upwards towards the flank, because the sub-cutaneous fascia, very close below, becomes more and more loose and porous as it passes upwards. Here is a condition, anatomical and physical at the same time. Capillary attraction is the probable cause of the phenomena in question.

The other fact is equally interesting. It consists in this ; that with certain patients who carry about a considerable infiltration, there comes over all the body a yellow tint of the skin, analagous to icterus, with the exception that the schlerotics preserve their natural state. This lasts five or six days. It is an observed fact which I cannot well explain to myself. I commend it to your researches.



*Sanguine effusions* circumscribed, truly constitute an affection by themselves. At the end of a certain time, they may be completely dispersed, which is exceptional, or more frequently you observe one of these three terminations : —

1st. The blood solidifies, and the tumor becoming more and more firm, ends by becoming altogether solid.

2d. It becomes more and more liquid, and forms a collection which may preserve its red color, or occasionally lose it.

3d. It forms a sort of chocolate-colored broth, with clots, thready masses, &c. This termination is a mean between the other two.

Now in all these cases treatment is of great efficacy ; it is also very various. At the commencement you can cure very quickly. You have seen that an infiltration may disappear rapidly ; when an *effusion* is situated in front of a bone, as the tibia, the cranium, you can change it into an infiltration. To do this, it is enough to crush the lump with the thumbs ; you press roughly, so as to break the fibres which op-

pose the expansion of the liquid. Immediately the phenomena is produced; the tumefaction disappears to give place to a depression, which you fill up with a graduated compress; you surround it with a bandage, and the patient recovers.

If you cannot proceed thus, you have recourse to resolvents, ointments, blisters, &c. The best is a cut with a bistoury. You empty the sac and make compression, which singularly facilitates the adhesion of the walls.\*

If the effusion is transformed into a hydrocele, or hematocele, you proceed as for the vaginal tunic; puncture it and inject iodine.

Finally, if the tumor has become solid, there is no other remedy than extirpation.

\* Something like this may be practised with those sanguine effusions seen upon the heads of newly-born children. If spirituous lotions do not readily disperse the tumor, it may be punctured with a lancet or fine trocar. Authors seem terribly frightened at the idea of this; experience regards it with favor. — W. C. B. F.

## DISEASES OF THE GENITO-URINARY ORGANS.

There are 209 cases : —

Accouchements, . . . . .	18
Diseases of the breast, . . . . .	45
Diseases of female genital organs, . . . . .	63
Diseases of male genital organs. . . . .	83

In all 126 females. Here the female element has the ascendancy, and you will understand why. First, the occupation has here no particular influence, indeed, they rather favor the female sex. Thus there are 18 accouchements, many more than the average, on account of the closing of the Maternité Hospital, at the beginning of the year. I shall say nothing more of them unless it is that there have been three deaths by metro-peritonitis. I pass on at once to the detail of other affections.

1st. *Affections of the breast.*—Our 45 cases, of which 43 were females, are thus divided:—

Abscess, . . . . .	22
Hypertrophy, . . . . .	1
Engorgements, . . . . .	3
Adenoid tumors, . . . . .	6
Cancers, . . . . .	13

*Abscess.*—For years I have insisted upon the anatomical classification of abscesses of the breast into *parenchymatous* or glandular, *sub-cutaneous* and *sub-mammary*. I do not wish to say that this is all, and that it is necessary to make an abstraction (of which I have been accused) of conditions of cause, nature, age, &c. I only affirm that all these abscesses commence by some one of these three points. This is the important fact.

If, besides, you have heard me almost always talk during this year, of glandular abscesses, it is because they are the most numerous and almost the only source of the other two varieties.

They form themselves, two kinds, according to their immediate origin. They may arise in



fact, in the interior of the glandular ducts ; in the *acini*, the least disturbance in the course of the milk, the least alteration in this liquid may give rise to them. On the other side, the cellular or conjunctive tissue intermixed, interposed between these ducts and these glands, can also be attacked ; for you know that this tissue is found everywhere ; there is no *cul-de-sac* so small that it may not line it. It is not the less a parenchymatous inflammation.

The pus once formed oftenest remains in the lobules, or rather it passes into the sub-cutaneous tissue ; finally it may pour itself into the profound tissue which is also very fascia-like. As to proportions, we have had this year in 22 abscesses, 4 only sub-cutaneous and 2 sub-mammary. You know that incision is the sovereign remedy for all these abscesses.

*Engorgements.* — This is a word which I dislike. I long ago discarded the term from the pathology of the uterus. But people still speak of engorgements of the breast, and I do like the rest. In truth, one encounters cases outside of

all cancerous affections, where the breast is swollen, as in hypertrophy, but it is at the same time painful, as in inflammation ; it is in sum, a sub-acute state, the reduction of which is easily obtained by the aid of poultices, and ioduretted or mercurial ointments.

*Adenoids.* — You know that I designate by this name, tumors of a benign nature, attached by no direct connection to the mammary tissue, presenting upon section and to the naked eye, a granulated aspect. Under the microscope you encounter all kinds of cells, excepting those which form the mass of cancerous tumors. They should be removed ; generally they do not return.

*Cancers.* — I have nothing particular to tell you of them here. We have had 13 cases — 1 male. The greater part have been extirpated. It is then in the statistics of operations that they will find their place.

All that I ought to tell you is, that none of the operations practised for extirpating adenoids have been followed by death, a result which

would have been very mortifying, as the affection is not fatal by itself.

2d. *Affections of the genito-urinary organs of the female.* — There are 63 examples : —

Abscesses and cysts of the labia majora, . . . .	10
Deviations of the uterus, . . . . .	5
Metrorrhagias, . . . . .	5
Pelvi-uterine inflammation, . . . . .	9
Affections of the ovary, . . . . .	7
Fibrous tumors of the uterus, . . . . .	8
Cancers, . . . . .	14
Five other cases not classified.	

*Abscess of the Labia Majora.* — This is an affection described only within thirty years. It results from blows, chafes, mechanical irritation of the sort that is observed in such a place.

Almost always the abscess is seated in the inferior half of the great lip, which seems to support the idea of M. Huguier, when he places the seat of it in the vulvo-urethral gland already described by Bartholin. I am not persuaded of the fact, because in these cases the abscesses ought almost always to remain fistulous. Now this is exceptional, and when this termination is pro-

duced, it is explained by the rapid march of the abscess, and the detachments which are the consequence of it.

Another fact for you to notice is, the offensiveness of the pus in spite of the absence of communication with the vagina or with the rectum. I have often insisted upon this catalogue of abscesses fetid by neighborhood ; I mean the neighborhood of canals traversed by air, as is noticed near the anus, the mouth, the thoracic walls, etc. I shall return to this subject in speaking of diseases of the anal region.

Remember only, that these abscesses ought to be opened early, if you wish that the walls, still preserving a certain thickness, may glue themselves together ; you will thus avoid fistula.

*Uterine deviations.* — By themselves they bring about no accident, except by the complications to which they may be joined. The ante-versions and retro-versions are less dangerous than the flexions ; the latter really cause a notable trouble in the functions ; the elbow formed by the union



of the body and the neck, sometimes prevents the fecundity of the female.

These deviations have been much discussed for twenty years. I have talked about them more than thirty years ; it was the origin of my quarrels with Lisfranc. He saw nothing but engorgements everywhere, and he had an infallible treatment in which the extract of hemlock and cold injections played a great part ; but the condition, *sine-qua-non*, was lying in bed six months or a year !

His error proceeded from this, that he mistook deviations of the uterus for engorgements. Really, if in a case of retro-flexion, for example, you make a vaginal examination, you readily touch the neck of the uterus, and a little behind you feel a tumor, which is simply the body of the uterus ; this Lisfranc took for an engorgement. Remember that these abnormal positions are not present without being accompanied by twinges, sensation of weight, pain more or less severe, which women exaggerate still more, and in considerable proportion.

A long discussion took place at the Academy on these engorgements, a discussion which I was enabled to call the most efficacious of resolvents ; it made the engorgements disappear, so that we no longer hear anything about them.\* I had a certain part in this result ; it was the origin of the enmity of Lisfranc.

Engorgements having disappeared, deviations held the track. I talked about them for a long time ; I had even imagined a sort of pessary, with a rigid shaft designed to enter the uterus to maintain it upright. I renounced it immediately, having recognized the possibility of excoriations, ulcerations, and even perforations of the womb, by the presence of this instrument.

But it was re-discovered by Simpson, and, moreover, in France, by Valleix, who did everything to popularize this practice. A new discussion at the Academy made the straighteners and the straightenings disappear, who went to join the engorgements ; and it was well done, for

\* See *Bulletin de l'Académie de Médecine*, 1849.

the inconveniences were real, and of the highest gravity.

The deviations then remain, which are real, and which it is necessary to remedy. It is always a subject for study, and will be for some time yet.

Imagine, in fact, the uterus suspended like a curtain in the pelvic cavity ; in front, the bladder essentially mobile, and varying incessantly ; behind, the rectum in the same condition, and, floating above all, the intestinal mass, which shakes about in every direction. How could you suppose that this organ should have a fixed direction ? and once deviated, how could you maintain it upright ? - All that anybody can do is to hold it up when it tends to come down.

Hence, all our females have been treated only with emollients, sometimes astringents, and above all, by the use of hypogastric belts. The latter have gained much by the different discussions to which I have referred. Vaunted by me since 1829, they have become popular little by little, and are firmly established in practice. Neverthe-

less, these belts do not act in the manner that many among you think, and even many practitioners have no exact idea of their mode of action. This is in what it consists :—

Imagine a skeleton standing erect, and you will see that the plane of the superior strait of the pelvis is strongly inclined forwards, so that the centre of gravity of the body is almost at the pubis. Fill up, in your imagination, this osseous box with the abdominal viscera, and you will see that all their weight falls in part upon the womb.

The belt has for its object exactly this effort ; if not to annihilate, at least, to moderate this weight. It acts like the hands of an individual, who, having a wound in the lower part of the belly, seeks to hold up the intestines which would escape from it. At least, it is the part which the concave plate, observed at the anterior part, ought to fulfil.

*Metrorrhagias.* — They are all connected either with fibrous tumors, cancers, pregnancy, perhaps with genital excesses. I have nothing particular to tell you about them, unless it is that I wish



to call your attention to this last cause, infinitely more frequent than is commonly believed.

Remark well, gentlemen, that the essential metrorrhagias tend more and more to disappear, according as the organic lesions are better understood. Those which are still designated under this name are almost all connected with irritations which the nature of the functions of the womb, and the repeated shocks to which it is, in certain cases, forcibly submitted, superabundantly explain.

*Metro-peritonites.* — They have shown you this important fact, namely, a local inflamed point is the origin of these accidents. All these women complain from the beginning of severe pains in the lower belly, and are extremely sensitive to pressure in the neighborhood of the uterus.

This is a very important fact, because there is, nowadays, a fatal tendency to rank these accidents under the name of puerperal fever, an affection of the whole system.

Reflect a little, meantime, upon the mechanism of confinement; this function so painful, and

sometimes so dangerous. It demands that by incessant and painful efforts, the foetus shall distend the neck of the womb, thin it, dilate it, so that it is often torn; the vagina stretched, the venous plexuses, the nerves, the cellular tissue all compressed, bruised, crushed like pomace in the press.

Is it astonishing that accidents result from all this? The cellular tissue, the uterus, are attacked, and immediately you have one of these pelvic uterine inflammations, which have been so much talked of in these latter days. Remember that it is little painful at its commencement, and often passes unperceived. All these parts heavily bruised, are, during the first days, little sensitive; you have a proof of it in the fact that, retention of urine is so frequent after confinement, and the existence of which women scarcely suspect.

But soon the inflammation gains the peritoneum; then by the veins, the lymphatics so numerous in this region, the morbid atoms are transported into the economy, and then appear

the signs of intoxication by septic matters, the typhoid phenomena, the earth-like complexion, feebleness of pulse, etc.

This is what I published forty years ago, in a thesis of one of my pupils. At this day, the clouds and vapors which left the mind without a satisfactory explanation, yet appearing to explain everything, are blown aside. The worst part of it is that chimeras are still pursued, and that leaving the substance to pursue the shadow, the essential point, here perfectly determined, is neglected.

You have witnessed the efficacy of certain treatment employed in good season; an anti-phlogistic treatment, essentially composed of repeated flying blisters upon the lower belly, mercurial frictions, baths, light purgatives, with some local bleedings. The employment of these different means most frequently averts suppuration. We have had in all 13 cases of metro-peritonitis; 9 females have been cured; 4 are dead.

*Fibrous tumors.* — Those among you who

have followed these observations, have been able to recognize this important fact; that not only can the hemorrhages be arrested, but that these tumors are susceptible of being diminished in volume, and in a notable manner. This fact has shown itself with three of our patients. In regard to treatment, it is the same as has been shown you above for inflammations. It would do no good to discuss the possibility of the fact; it exists, you have seen it; the explanation will be found.

*Cancers.* — They have shown that they do not get well, which is not new; and that they do not occasion great pain, which is a little more new. A great number even are not painful from the commencement. Here is something important to know; as a general rule (8 times out of 10) the uterine cancer runs through all its periods without notably rousing the sensibility; it provokes suffering only when arriving at its last stage, it invades the cellular tissue, the vessels, and, above all, the nerves. Now, exactly the contrary is commonly taught.



It is a greater evil than one would think. In fact, what happens? In practice, one scarcely notices the terrible affection in the beginning; on questioning the woman, and upon her replying that she scarcely suffers anything, the practitioner immediately banishes the idea of it, and does not propose an examination, always delicate and often difficult to obtain; the sole means of diagnosis thus escapes him. Then at the end of five, six months, or more, he finds a frightful cancer in full evolution.

Here is a most real fact; I have seen numerous cases of it; I have seen women who did not suspect, any more than their friends, the terrible affection which was gnawing away their uterus; therefore I have dwelt upon it, in order to keep you from a like error.

3d. *Affections of the genito-urinary organs of the male.* — We count 83 examples; the following are the results: —

Cured, . . . . .	63
Relieved, . . . . .	11
Died, . . . . .	3
Not treated, . . . . .	6
Total, . . . . .	<hr/> 83

The last six have only been transient in the wards.

The *orchites* are 35 in number. Left to themselves, they last about twenty days; an important fact to know, if you wish properly to appreciate the efficacy of such and such a remedy and its influence upon the march of the disease.

Now, you have been able to witness the happy effect of the means I have employed for a long time; two or three pricks made with the point of a lancet constitute the most powerful and inoffensive resolvent. If the entire duration of the affection is abridged only four or five days, the inflammation and the pain are immediately calmed, and the patient can await his complete cure tranquilly and without great suffering.

These are things which it is necessary to see in order to be convinced at once both of the efficacy of the treatment, and moreover of its harmlessness, which would not appear at first sight; it is infinitely less painful than the application of leeches. In regard to pricking the testicle, it is insignificant. I have no need to add that re-

pose and emollient topical applications may contribute to complete the cure. With this treatment, our orchites last fifteen days.\*

*Hydroceles* have been treated by puncture and injection of iodine ; † all got well, at least of the

\* M. Velpeau probably alludes to opening the scrotal veins to relieve congestion. Vidal de Cassis, of Hôpital Midi, has for many years advocated and practised plunging a lancet or bistoury into the *tunica albuginia*. In 1846, Mr. Henry Smith re-discovered this method by an error of diagnosis; making a deep incision into the testicle to evacuate imaginary pus, he found on the morrow his patient relieved of an orchitis. Dr. W. Spencer Watson has recently appeared in print to say that the pain and tension soon returns; that bleeding has once occurred. He recommends the puncture should involve the tunica-albuginia, as well as the tunica-vaginalis, and that the testicle be strapped. The professional experience of the translator has shown him that calomel and opium administered so as to produce slight salivation, is a sure cure for orchitis. The inunction of mercurial ointment over the inflamed gland may be coupled with this. Mr. Butcher, of Dublin, in some published cases of obstinate orchitis, found this to be the weapon with which, in his first case, he finally succeeded. Yet, amusingly enough, in his following cases, let it fall from his hands, going back to antimonials and salines, with fomentations and leeches, again to recur to calomel, and again to succeed; but never at last fully recognizing that had he used it at first, he would have saved much time and affliction to his patient. — W. C. B. F.

† This is simply a mixture, in equal parts, of water and tincture of iodine.

simple hydroceles. The complicated ones have resisted more or less. I have often enough insisted this year, upon the differences which are observed upon this subject. I solely wish to remind you that serous cavities are as much better modified by iodine, as the walls are more smooth, and the liquid more yellow; rough walls, hematic cavities are, on the contrary, in the worst condition. These differences are important to know, relatively to predict the result for the patient or his family.

One case of *strangulation of the testicle* presented itself at the beginning of the year; it was published. (See *Gazette des Hôpitaux*, Feb., 1865.) It is an interesting observation, on account of the rarity of analagous facts, and the almost identity of the symptoms with those of strangulated hernia.

I have nothing to tell you about affections of the *urethra*. We have had only 5 examples, because we do not admit them into the hospital. In fact, the treatment of strictures by dilatation, can be made outside. In regard to internal ure-



throtomy, I think it useful only for fibrous strictures.

The 4 cases of *phymosis* which have been in the hospital, have shown us the satisfactory result due to an old method, supplanted in this day by circumcision. In this latter proceeding, if the wound suppurates, there is formed a circle, a hard ring, which may bring back the phymosis.

Now the ancient proceeding which I still employ, consists in simply cutting the prepuce from before, backwards. The villanous aspect of parts operated upon has been objected to it; it is an argument, but it is easy to remedy this inconvenience by cutting underneath the gland; so that as circumcision also gets well, it is an affair of taste, and I do not wish to attack any one. I only ask that I may be allowed to consider the other method just as good.\* There have been 2 cases of *paraphymosis*; I have always reduced them, even those which appeared

\* M. Velpeau here refers to circumcision as accomplished by cutting off merely the end of the prepuce. Circumcision., as done by M. Ricord, is followed by no such results. — W. C. B. F.

most irreducible. To accomplish this, I grasp the ring behind with a well-dried bit of linen, whilst I push back the gland with the thumbs applied above.† Two cases of *varicocele* have been cured by the old method of ligature under the skin.

† Paraphymosis is best reduced by the method of Mr. Cooper Forster, of Guy's Hospital. "The patient is placed on his back, the surgeon grasps the penis firmly with his right hand and proceeds to lift him bodily up; the prepuce invariably slips forward, and the affection is at once relieved. There is no danger in the process; the penis can bear all the strain that can be so applied. Division by a director and bistoury is unnecessary. Pulling the prepuce forwards whilst the glans is pushed back is tedious and inefficient. When the prepuce is restored to its position, a state of phimosis is produced which subsides in a few days under the use of cold applications." The stricture yields with a slight tearing sound. It is best to place children under ether for this operation.

W. C. B. F.

## AFFECTIONS OF THE ANAL REGION.

We have been able to observe 54 examples, thus divided according to termination: —

Cured, . . . . .	29
Benefited, . . . . .	8
Without change, . . . . .	9
Not treated, . . . . .	7
Died, . . . . .	1
	—
Total, . . . . .	54

*Fistulas.* — There have been 46 cases — 24 males, 22 females; this is almost the normal proportion. Those among you who have assisted at the operations have been able to see that the simple incision is rarely sufficient. Almost always there are sinuses, detachments, whence result kinds of promontories, fleshy bluffs, which it is necessary to excise. Moreover the first incision finished upon the director, you have often seen me, by the aid of a blunt-pointed bistoury,

plunge deeply, sometimes cutting various fibres. It is then, in short, a sufficiently complex operation, and in a great majority of cases it cannot be accomplished by the aid of a ligature or *écrasement*, which destroys only a single partition.

*Abscesses.* — They ought to be ranked immediately after fistulas, of which they are almost always the origin. We have had 10 of them, all with males. These abscesses may, without communicating with the rectum, proceed either from the interior of the belly or the neighboring bones; then once open, they give rise to a fistula more or less complete. Now, abscesses of the anal region may become fœtid without communicating with the rectum; it is well not to forget this in regard to diagnosis.

It was in 1826 that, having opened a dead body with a fistula not operated upon, I was put upon the track of this discovery. There was quite a large abscess furnishing an infectious pus; some had diagnosed a complete fistula. I could not discover, by the most minute research,



a communication with the rectum ; the track of the fistula mounted to the sacrum. This fact awakened my attention, and since then I have met with a great number of analagous cases.

I have also discovered that all abscesses developed in the neighborhood of organs communicating with the interior, may become foetid. This is observed in the neighborhood of the larynx, cheek, walls of the chest, &c., and the odor participates with that of neighboring decomposed matters. You will understand how much the knowledge of these facts can, in certain cases, mitigate the prognosis.

*Fissures.* — We have had 4, all cured by the employment of meshes covered with ointment *de la mère* softened with oil ; but it is right that you should understand that these were not true fissures. I will explain myself.

Formerly, all ulcerations of the anus were confounded under this name, and many practitioners still confound them. It was exactly in regard to this that Boyer made his essay, which has remained one of his most remarkable works.

He perfectly showed that it was necessary to distinguish on one side, the *fissure* properly so called, that is to say, a crack sufficiently cleanly cut, a little indurated, ordinarily perpendicular to the sphincter ; this is never cured without an operation, and all the ointments in the world can accomplish nothing.

But, on the other side, superficial excoriations also exist near the anus, having no particular characteristic ; these are the ones M. Trousseau cures by rhatany ; and in making use of the word *fissures*, he has brought back to us the confusion of the times before Boyer, and against which I wish to guard you.

As to the other affections of the anal region, there were some hemorrhoids, a stricture of the rectum, which for the most part have not remained in our wards.

## AFFECTIONS OF THE EYES.

We have had 75 cases; 45 males and 30 females; they are divided thus, according to the result: —

Cured, . . . . .	42
Benefited, . . . . .	7
Without change, . . . . .	9
Not treated (transient), . . . . .	17
	—
Total, . . . . .	75

This is, relatively, a small number, particularly if I tell you that I have had, in a single year, 250 cases. You will see the reason of this falling off. From 1830 to '35, I was much occupied with diseases of the eyes, so I took in the largest number possible, and as the thing became known, they were sent to me from everywhere.

When I had studied them to my satisfaction, and, to use a common expression, my bag was almost empty, they were no longer interesting to

me, and I now admit these patients into the hospital, only in the proportion they are commonly received. Nevertheless, let us see what we have learned from these 75 observations.

*Conjunctivitis.* — Whatever its form, it may be cured by a lotion of nitrate of silver. For ordinary conjunctivitis, that which is called catarrhal, a weak solution will suffice (one to two grains to an ounce). For the purulent forms, 15 to 30 grains to an ounce are necessary. Solid nitrate of silver is still more efficacious.

For *inflammation of the eyelids*, the ointment is preferable to the lotion; the latter, although passing rapidly, is imbibed by the conjunctiva, whilst upon the borders of the eyelids the water runs off. The ointment rubbed in adheres perfectly. The formula that I employ is one of the most simple; as many centigrammes of nitrate of silver as grammes of lard. (Example, 2 grains to 2 drachms.)

For *inflammations of the cornea* and *acute iritis*, mercury is the best remedy. I give calomel in small doses, in order to produce saliva-



tion quickly ; and you will have noticed, that as soon as this appears the eye grows white, the redness is lessened, and the photophobia disappears.

As this is a serious medication, it is unnecessary to resort to it unless there is great urgency, when the cornea is greatly inflamed. Besides this, it has been greatly slandered. Formerly, salivation was pushed to the production of severe disorders, falling out of the teeth, necroses of the maxillary bones, etc. These souvenirs have remained in the public mind, although in the mean time all these dangers have disappeared, and for a very simple reason ; the medicine is stopped as soon as salivation appears. Astringent gargles are given, such as borax, alum, and above all, chlorate of potassa. It is very rare, that with these precautions, salivation is not moderated immediately, and commonly in eight to ten days the patient is cured both of his ophthalmia and of his sore mouth.

I shall take pains, also, to show you the most prominent points of the diagnosis. Two patients

present themselves to you with red, inflamed eyes ; one looks you in the face, lets you examine him readily ; conjunctivitis ; the other holds his head down, eyelids closed, forehead wrinkled, tears running down his cheeks ; inflammation of the cornea.

Examine them more attentively. With the first, you find a livid, violet redness, with large vessels arranged in tendrils, the whole lightly granulated, and augmenting in intensity from centre to circumference, the boundaries of the cornea remaining white. With all this, little lachrymation and ordinarily little photophobia. Here is a well-marked conjunctivitis.

With the second, on the contrary, you see the circumference of the eye almost normal, but about the cornea, like petals round the disc of a daisy, red vessels disposed like rays ; then, lachrymation, photophobia, and often upon the cornea, ulcers, stains, or abscesses, which leave you no doubt as to the existence of inflammation of the cornea.

Moreover, the other signs ought not to be neg-

lected. Time does not permit me to dwell upon them. I only wish to point out these distinctions, pathognomonic so to speak, and by the aid of which you may establish the basis of a precise diagnosis.

## STATISTICS OF OPERATIONS.

This is one of the most difficult to establish, for the reason that the word *operation* is very badly defined. A crowd of incisions which are practised daily, do not take this title, although they often merit it by the gravity of the consequences they entail. However it may be, here is the table for the current year.

120 operations have been performed; of this number, 99 were cured, 15 died, 6 were without benefit.

			<i>Cured.</i>	<i>Died.</i>
Operations upon the Breast, . .	19	of which	12	6
Cancroids, . . . . .	13	" "	10	3
Different tumors, . . . . .	14	" "	10	3
Amputations, . . . . .	8	" "	8	0
Operations upon Anus, . . . .	16	" "	15	0
Operations on Genital organs, .	37	" "	35	2
Cataracts, . . . . .	5	" "	2	0
Different operations, . . . . .	8	" "	7	1
<hr/>				
Total, . . . . .	120		99	15



At first sight of this table, you learn this important fact; that operations are not dangerous because they are great, but because they concern living flesh. In 8 amputations not a single death, whilst the ablations of the cancrroid give 3. Do not forget this in civil practice, when people will not forget to put to your account, the fatal terminations of these cases, in appearance trivial, if you have not taken precautions in advance.

The dressings have been very various; nothing clear can be stated of them. As you will see, the greater part of the patients have succumbed to erysipelas; those operated upon, dressed with alcohol, have not been kept from it. At least, it is learned, that this mode of dressing is as inoffensive as any other; try it again, because in like circumstances you should never despair.

*Operations on the Breast.*—There have been 16 ablations; 12 for schirrus and encephaloids, and 3 cauterizations; 4 adenoid tumors have been taken away with complete success. It is relatively fortunate that the cases of death have

taken place with women attacked with cancer, a disease inevitably mortal, so to speak.

Cauterizations have been practised by the use of the caustic *sulfo-safrané*. Whatever may be the innoxiousness of caustics, we have, nevertheless, to deplore a death by erysipelas, which proves that their immunity is as far from being as complete as has for a long time been believed.

*Cancroids*. — Out of 13 operations 3 died of erysipelas. It is great while since this terrible complication made such ravages with us; before this year I was fifteen months almost without hearing it spoken of in my wards.

*Different tumors*. — Under this title are grouped, cancers, fibro-plastics, fibrous tumors, taken from different regions of the body. There were 10 cures and 3 deaths, — 2 by erysipelas, 1 by purulent infection. Here again we have a case of death following the application of caustic to a tumor of the neck.

*Amputations and resections*. — The 8 cases operated upon have been cured, although an amputation of the thigh and a disarticulation of the

wrist are comprised among the number. This confirms what I told you at the commencement, of the relative danger of great operations.

*Operations upon the anus.* — There have been 16, thus divided : —

Fistulas, . . . . .	13
Fissures, . . . . .	1
Hemorrhoids, . . . . .	1
Stricture of the rectum, . . . . .	1

This last operation has consisted in the ablation of condyloma situated at the orifice ; the result has been doubtful. In regard to the other 15 operations, they have been followed by complete success.

*Operations upon the genito-urinary organs.* — These are the most numerous ; there are 37, of which 32 were males. Hydroceles were dominant ; the injection of iodine has constantly succeeded. (See above.)

Thus you see the greater part of the deaths are due to erysipelas ; the others to purulent infection, concerning which there remains one word for me to tell you.

*Purulent infection.*—During forty-five years, since I published my first work, the therapeutics of it has not sensibly progressed. If you are curious to make a comparison you have only to read the *Revue Médicale* of 1826, and particularly the numbers for May, 1827. All that is written there may be said again to-day. I had already tried then, the greater part of the medications still used; quinine, anti-septics, purgatives, &c.

Nevertheless, they have not experimented badly since, and it is proper to acknowledge that up to the present time, nothing cures it, not even aconite, so much boasted. We have tried it this year, in all doses and without any success.

I only wish to guard you against an error. Certainly the diagnosis of purulent infection is ordinarily easy, nevertheless, some slow suppurations, local, but misunderstood by reason of the fevers which they occasion, may impose upon us. On the other side, is it not very probable, even certain, that the organism can disembarass



itself of the purulent affection in a slight degree ? Because, certainly here is a poison, it cannot be doubted ; and if it is absorbed in a small quantity, the economy can reject it, and medication will appear to have succeeded.

Remember, then, and this is very important, that the remedy is not yet found ; this is not to say that you should abandon the attempt, but pursue it with zeal. Truth is found sooner or later ; it is only a question of perseverance, and of not allowing error to impose itself for it.

Here the case is difficult. What is this poison ? What are these morbid atoms ? Are they living, microscopic beings, as recent researches tend to make one believe ? And if they are little beasts attacking the life of the great beast called man, how shall we find out the poison which can kill them also ? and when you have found it for one kind, it will be necessary to find it for the others, and who knows the number of them ?

Behold, gentlemen, a vast subject for research, in the midst of so many others ; for nothing

shocks me more than to hear said every day, even by young people, that science is accomplished. Error! Almost everything is yet to do. You see by this rapid table, by these cases so numerous, before which we halt disarmed, there will be such for years and centuries.

Put yourselves, then, to the work. Know, moreover, that the only source of success, that which never fails, is above all labor, consecrated to science, and particularly to medicine, where, rendering yourselves useful to yourselves and to your fellow-creatures, you will pursue the realization of a progress, whose termination is infinite.



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